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8
9 **BEFORE THE**
BOARD OF REGISTERED NURSING
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

Case No. *2013-233*

12 **RUTH LITECKY MAINA**
27525 East Trail Ridgeway, Apt. 2099
13 Moreno Valley, CA 92555

14 **Registered Nurse License No. 679031**

A C C U S A T I O N

15 Respondent.

16
17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
20 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
21 Consumer Affairs.

22 2. On or about May 9, 2006, the Board of Registered Nursing issued Registered Nurse
23 License Number 679031 to Ruth Litecky Maina (Respondent). The Registered Nurse License
24 was in full force and effect at all times relevant to the charges brought herein and expired on May
25 31, 2012 and has not been renewed.

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(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Section 4060 of the Code states:

No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer. Nothing in this section authorizes a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices.

9. Health and Safety Code section 11170 states that no person shall prescribe, administer, or furnish a controlled substance for herself.

10. Health and Safety Code section 11173, subdivision (a) states:

No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

COST RECOVERY

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

12. Ativan, a brand name for lorazepam, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(16), and is a dangerous drug pursuant to

1 Business and Professions Code section 4022. Lorazepam is used in the treatment of anxiety
2 disorders and for short-term (up to 4 months) relief of the symptoms of anxiety.

3 13. Dilaudid, a brand name for hydromorphone, is a Schedule II controlled substance as
4 designated by Health and Safety Code section 11055(b)(1)(J) and is a dangerous drug pursuant to
5 Business and Professions Code section 4022.

6 14. Fentanyl, is a Schedule II controlled substance as designated by Health and Safety
7 Code Section 11055(c)(8), and is a dangerous drug pursuant to Business and Professions Code
8 section 4022. Fentanyl is a narcotic (opioid) pain medicine and can be delivered through
9 transdermal Duragesic patches that deliver a continuous dose of the potent narcotic painkiller
10 fentanyl for a period of three days. The patches are prescribed for chronic pain when short-acting
11 narcotics and other types of painkillers fail to provide relief.

12 15. Tylenol #3, a brand name for acetaminophen with codeine, is a Schedule III
13 controlled substance as designated by Health and Safety Code section 11056, and is a dangerous
14 drug pursuant to Business and Professions Code section 4022.

15 **KAISER PERMANENTE MORENO VALLEY COMMUNITY HOSPITAL**

16 16. Respondent was employed as a Registered Nurse at Kaiser Permanente Moreno
17 Valley Community Hospital (hereinafter "Kaiser Moreno Valley") from June 20, 2008 until her
18 involuntary termination on November 29, 2010 for misconduct. Respondent's last day of
19 employment at Kaiser Moreno Valley was September 26, 2010. During her employment at
20 Kaiser Moreno Valley, Respondent worked the night shift (1900 hours to 0700 hours) in the Step-
21 Down Unit.

22 17. In August, 2010, a random audit of Respondent's Pyxis¹ activity was performed for
23 the period March 2, 2010 through August 16, 2010. The audit revealed that Respondent

24 ¹ Pyxis is a trade name for the automatic single-unit dose medication dispensing system
25 that records information such as patient name, physician orders, date and time medication was
26 withdrawn, and the name of the licensed individual who withdrew and administered the
27 medication. Each user/operator is given a user identification code to operate the control panel.
28 Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not
given to the patient are referred to as "wastage." This waste must be witnessed by another
authorized user and is also recorded by the Pyxis machine.

withdrew a total of 38 mg of Dilaudid IV from Pyxis on 19 occasions during this period, followed by documented wastage of all this medication. The average number of withdrawals for all Registered Nurses at Kaiser Moreno Valley that resulted in documented wastage was three.

18. The large amount of Dilaudid that Respondent wasted led to a further audit. The second audit revealed the following:

a. **Patient 1: March 3, 2010:** Respondent was not scheduled to work on March 3, 2010 because she was scheduled to attend a meeting. Within an hour of arrival, Respondent documented withdrawal of 2 mg Dilaudid IV, administration of 0.5 mg Dilaudid IV at 0800 and wastage of 1.5 mg for Patient 1, who was another nurse's patient. The patient's nurse did not ask Respondent to medicate the patient and the medical records indicated the patient had "no pain" during the 24 hours before and after Respondent administered Dilaudid.

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Dilaudid 0.5 mg Inj Q4 hrs PRN	Dilaudid 2 mg Inj @ 0804 hours	Dilaudid 0.5 mg @ 0800 hours	Dilaudid 1.5 mg	Not Respondent's patient. Patient had no complaints of pain before or after administration of Dilaudid.

b. **Patient 2: March 5, 2010:**

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Lorazepam Inj 0.5 mg one time only	Lorazepam 2 mg Inj @ 2120 hours	None	Lorazepam 1.5 mg	Lorazepam 0.5 mg

c. **Patient 3: April 4, 2010:**

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Dilaudid 1 mg IV Q6 hrs PRN	Dilaudid 2 mg Inj @ 0403 hours	Dilaudid 1 mg @ 0400 hours	Dilaudid 1 mg	None

	Dilaudid 2 mg Inj @ 0921 hours	Dilaudid 1 mg @ 0900 hours		Dilaudid 1 mg
	Dilaudid 2 mg Inj @ 1625 hours	Dilaudid 1 mg @ 1600 hours		Dilaudid 1 mg

d. Patient 4: April 19, 2010:

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Dilaudid 1 mg IV Q4 hrs PRN	Dilaudid 2 mg Inj @ 0102 hours by another nurse	Dilaudid 1 mg @ 0400 hours by another nurse	Dilaudid 1 mg by another nurse	None
	Dilaudid 2 mg Inj @ 0448 hours	Dilaudid 1 mg Inj @ 0400 hours	Dilaudid 1 mg	None
	Dilaudid 2 mg Inj @ 0459 hours		Dilaudid 1 mg	Dilaudid 1 mg

e. Patient 5: May 6, 2010:

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Dilaudid 0.5 mg IV every two hours	Dilaudid 2 mg Inj @ 2031 hours when the patient was discharged at 2025 hours and had previously been administered Dilaudid by another nurse at 2021 hours on 5/6/2010.		Dilaudid 1.5 mg	Removal of Dilaudid 2 mg for a patient not assigned to Respondent and discharged 6 minutes before removal of Dilaudid.
			Dilaudid 0.5 mg at 2034 hours	

f. Patient 6: May 30, 2010: On May 30, 2010 at 2105 hours, Respondent withdrew Dilaudid IV 2 mg and documented wastage of 1 mg at 2144 hours. There is no documentation of administration of the remaining 1 mg.

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Dilaudid 0.5 mg IV Q4 hrs PRN	Dilaudid 2 mg Inj @ 2105 hours		Dilaudid 1 mg	Dilaudid 1 mg
	Dilaudid 2 mg Inj @	Dilaudid 0.5 mg	Dilaudid 1.5	None

	2144 hours by another nurse	@ 2100 hours	mg	
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g. Patient 7: June 13, 2010:

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Tylenol # 3 300-30 mg 1 tablet Q6 hours PRN	Tylenol #3 1 tablet	None	None	This order was discontinued as of 5/30/10 @ 2142 hours. 1 tablet Tylenol #3.

h. Patient 8: August 4, 2010:

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Dilaudid 2 mg IV Q4 hrs PRN	Dilaudid 2 mg Inj @ 1915 hours	None	None	Dilaudid 2 mg

i. Patient 9: August 7, 2010:

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Dilaudid 0.5 mg IV one time only (ordered at 2130 hours)	Dilaudid 2 mg Inj @ 2008 hours (withdrawn before order)	None	Dilaudid 1.5 mg	Dilaudid 0.5 mg
	Dilaudid 2 mg Inj @ 2128 hours	Dilaudid 0.5 mg Inj @ 2100 hours	Dilaudid 1.5 mg	None

j. Patient 10: August 17, 2010:

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Dilaudid 0.5 mg IV Q3 hrs PRN	Dilaudid 2 mg Inj @ 0504 hours	None	None	Dilaudid 2 mg

19. As part of the Board's investigation, a Controlled Substance Utilization Review and Evaluation System report was obtained regarding Respondent's narcotic prescription history for the period May 6, 2008 through May 6, 2011. The report indicated Respondent was prescribed

1 Lorazepam, Ambien, hydrocodone, codeine, and Zolpidem. Respondent had 19 different
2 physicians prescribing these drugs to Respondent during this period of time.

3 **FIRST CAUSE FOR DISCIPLINE**

4 **(Unprofessional Conduct – Kaiser Permanente Moreno Valley Community Hospital)**

5 20. Respondent is subject to discipline under Code section 2761, subdivision (a) for
6 unprofessional conduct in that Respondent withdrew controlled substances purportedly for
7 patients of Kaiser Moreno Valley without documenting administration and/or wastage of drugs,
8 withdrew controlled substances for a patient she was not assigned, withdrew controlled
9 substances for a patient who had been discharged, and withdrew controlled substances when there
10 was no longer a physician's order for the drug, as more fully set forth in paragraphs 16-19 and
11 incorporated herein as though set forth in full.

12 **SECOND CAUSE FOR DISCIPLINE**

13 **(Obtained Controlled Substances – Kaiser Permanente**
14 **Moreno Valley Community Hospital)**

15 21. Respondent is subject to discipline under Code section 2762, subdivision (a) for
16 unprofessional conduct in that Respondent obtained or possessed controlled substances in
17 violation of law, specifically Code section 4060 and Health and Safety Code sections 11170 and
18 11173(a), when Respondent withdrew controlled substances purportedly for patients of Kaiser
19 Moreno Valley without documenting administration and/or wastage of the drugs, withdrew
20 controlled substances for a patient she was not assigned, withdrew controlled substances for a
21 patient who had been discharged and withdrew controlled substances when there was no longer a
22 physician's order for the drug, as more fully set forth in paragraphs 16-19 and incorporated herein
23 as though set forth in full.

24 **THIRD CAUSE FOR DISCIPLINE**

25 **(Falsify or Make Grossly Incorrect and/or Inconsistent Entries in Records of Kaiser**
26 **Permanente Moreno Valley Community Hospital)**

27 22. Respondent is subject to discipline under Code section 2762, subdivision (e) for
28 unprofessional conduct in that Respondent falsified or made grossly incorrect and/or inconsistent

1 entries in Kaiser Moreno Valley's hospital records when she documented administration of
2 medication to a patient to whom she was not assigned, when she purportedly withdrew controlled
3 substances for a patient who had been previously discharged, and when she purportedly withdrew
4 controlled substances for a patient whose order for the drug had been previously discontinued, as
5 more fully set forth in paragraphs 16-19 and incorporated herein as though set forth in full.

6 **INLAND VALLEY MEDICAL CENTER**

7 23. Respondent was employed as a Registered Nurse at Inland Valley Medical Center
8 from November 10, 2009 through November 4, 2010. She worked in the Progressive Care Unit,
9 or PCU.

10 24. On November 3, 2010 at about 0100 hours, Patient # ---994 complained of pain and
11 requested his pain medication, which was Dilaudid. The patient's assigned nurse, A.C.,
12 attempted to withdraw the medication from Pyxis but received a message from Pyxis that it was
13 "too soon to give." The nurse asked other nurses in the unit if they had given the patient any pain
14 medication in the last half hour and they denied doing so. The patient stated he had not been
15 given pain medication since the day shift at about 1800 hours.

16 25. A review of Pyxis records revealed that Respondent withdrew Dilaudid at 0012
17 hours. Respondent denied removing the medication and stated that someone must have come
18 after her and withdrawn the medication from Pyxis before she "closed out" of Pyxis. An
19 investigation of the "time out" period for Pyxis was performed by C.D. C.D. determined that
20 Pyxis will log off a user 30 seconds after activity ceases. The last time Respondent withdrew
21 medication from Pyxis was at 2351 hours, 20 minutes before Dilaudid was removed at 0011
22 hours.

23 26. As a result of this incident, Respondent's medication withdrawal and administration
24 records were audited. The audit revealed the following:

25 a. **Patient #---700 on October 4, 2010:** Respondent withdrew 1 mg Dilaudid Inj at
26 2002 hours for another nurse and did not chart administration or wastage.

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b. Patient #---068 on October 10, 2010:

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Dilaudid 2 mg IV Q4 hrs PRN	Dilaudid 2 mg Inj @ 0058 hours	Dilaudid 2 mg at 0058 hours	None	None
	Dilaudid 2 mg Inj @ 0407 hours	Dilaudid 2 mg @ 0455 hours	None	None
	Dilaudid 2 mg Ing @ 0546 hours	None	None	Dilaudid 2 mg

c. Patient #---056 on October 10, 2010:

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Dilaudid 1 mg Q2 hrs PRN	Dilaudid 1 mg Inj removed @ 2053 hours	Dilaudid 1 mg @ 2050 hours	None	None
	Dilaudid 1 mg Inj Removed @ 2252 hours	In Nursing Notes charted @ 2250 hours as administered but that vial had to be wasted	Waste not reflected in Pyxis records	Amount administered was not charted on MAR

d. Patient #---068 on October 13, 2010:

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Dilaudid 2 mg IV Q4 hrs PRN	Dilaudid 1 mg Inj @ 2003 hours	Dilaudid 1 mg at 2003 hours	None	None
	Dilaudid 2 mg Inj @ 2122 hours		Cancelled removal	None
	Dilaudid 2 mg Inj @ 2124	Dilaudid 1 mg @ 2126 hours	Dilaudid 1 mg wasted @ 2124	Withdrawal was too soon
	Dilaudid 1 mg Inj @ 2128 hours		Dilaudid 1 mg at 2150 hours	None

e. Patient #---874 on October 19, 2010:

Ordered	Withdrawn by Respondent	Charted as Administered	Wasted	Discrepancy
Dilaudid 2 mg IV Q3 hrs PRN	Dilaudid 2 mg Inj @ 1949 hours		Charted as wasted at 2000 but not wasted	Dilaudid 2 mg

			in Pyxis	
	Dilaudid 2 mg Inj @ 2222 hours	Dilaudid 2 mg Inj @ 2220 hours		None
	Dilaudid 2 mg Inj @ 0053 hours	Dilaudid 2 mg Inj @ 0058 hours		None

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Inland Valley Hospital)

27. Respondent is subject to discipline under Code section 2761, subdivision (a) for unprofessional conduct in that Respondent withdrew controlled substances purportedly for patients of Inland Valley Hospital without documenting administration and/or wastage of drugs and withdrew controlled substances sooner than ordered and Respondent failed to document administration in the patient's Medication Administration Record, as more fully set forth in paragraphs 23-26 and incorporated herein as though set forth in full.

FIFTH CAUSE FOR DISCIPLINE

(Obtained Controlled Substances – Inland Valley Hospital)

28. Respondent is subject to discipline under Code section 2762, subdivision (a) for unprofessional conduct in that Respondent obtained or possessed controlled substances in violation of law, specifically Code section 4060 and Health and Safety Code sections 11170 and 11173(a), when Respondent withdrew controlled substances purportedly for patients of Inland Valley Hospital without documenting administration and/or wastage of the drugs, and withdrew controlled substances sooner than ordered and Respondent failed to document administration in the patient's Medication Administration Record, as more fully set forth in paragraphs 23-26 and incorporated herein as though set forth in full.

SIXTH CAUSE FOR DISCIPLINE

(Falsify or Make Grossly Incorrect and/or Inconsistent Entries in Records of Inland Valley Hospital)

29. Respondent is subject to discipline under Code section 2762, subdivision (e) for unprofessional conduct in that Respondent falsified or made grossly incorrect and/or inconsistent entries in Inland Valley Hospital's records when she documented withdrawal and administration of controlled substances to a patient who denied receiving such medication and when she charted

1 administration of controlled substances in Nursing Notes but not in the patient's Medication
2 Administration Record, and when she charted wastage of controlled substances in Nursing Notes
3 but not in Pyxis, as more fully set forth in paragraphs 23-26 and incorporated herein as though set
4 forth in full.

5 **REDLANDS COMMUNITY HOSPITAL**

6 30. On February 3, 2011, Respondent was employed as a registry nurse by Premier
7 Healthcare Services and was assigned to work the night shift (1900 hours to 0700 hours) at
8 Redlands Community Hospital. She was assigned two patients on February 3, 2011.

9 31. On February 3, 2011 at 2135 hours, one of Respondent's assigned patients called for
10 Respondent. Respondent could not be located. During the search for Respondent, G.W. passed
11 through the break room and saw that the bathroom door was closed and locked. G.W. heard the
12 sound of running water and snoring from the bathroom. When there was no response to G.W.'s
13 knocks, G.W. called an employee from the engineering department to unlock the door. After the
14 door was unlocked and opened, G.W. saw Respondent slumped over the toilet with a small
15 amount of blood on her forehead and blood on her right hand. Respondent was unconscious.
16 There was a small amount of vomit on the floor beside a bloody tourniquet and a used syringe.
17 There was another used syringe under the bathroom mirror. A Code Blue was called at 2143
18 hours.

19 32. The Code Blue team arrived. When Respondent's clothes were cut off, a syringe was
20 found under her sleeve and against her arm. A Fentanyl patch was found on Respondent bearing
21 the date and time of issuance to patient #---400. An IV was started and 2 doses of Narcan were
22 administered to Respondent. At 2158 hours, Respondent awakened and was transported to the
23 emergency department. Respondent refused to have her blood drawn and refused to give a urine
24 specimen.

25 33. At 2335 hours it was noted that the Fentanyl patch placed on patient #---400 at 0900
26 hours was missing from the patient and a new patch was placed.

27 34. Upon further investigation, it was discovered that Respondent withdrew one 1-mg
28 syringe of Dilaudid for Patient #---647 on February 3, 2011 at 2050 hours, wasted 0.25 mg

1 Dilaudid, and documented administration to this patient of 0.25 mg. The remaining 0.5 mg
2 Dilaudid was not accounted for.

3 35. Respondent was terminated from her employment with Premier Healthcare Services
4 on February 16, 2011 for patient abandonment and use of controlled substances.

5 36. On July 11, 2011, Respondent was interviewed by an investigator for the Board.
6 Respondent was uncooperative at first, but later stated, "Yes, I'm an addict." Respondent
7 admitted she became an addict around September 2010 when she was having marital and work
8 problems, and was suffering from depression. Respondent explained that her addiction started
9 when she was prescribed pain killers for endometriosis. At about this same time, she was in a car
10 accident and was prescribed more painkillers. From that moment on, Respondent stated she
11 continued to take medication for pain. She admitted to "dosing" at work but declined to disclose
12 her drug of choice or the amount of drugs she was taking.

13 37. Respondent admitted that on February 3, 2011, she overdosed on narcotics. She had
14 used her husband's medication. Respondent admitted that there was always medication in her
15 home because her husband suffers from fibromyalgia. Respondent stated that she had not
16 planned to go in to work on February 3, 2011 and that she had taken some Vicodin earlier in the
17 day. While at work, Respondent stated she "shot herself with whatever medication she had taken
18 from home." Respondent denied having or taking a Fentanyl patch from a patient.

19 **SEVENTH CAUSE FOR DISCIPLINE**

20 **(Unprofessional Conduct – Redlands Community Hospital)**

21 38. Respondent is subject to discipline under Code section 2761, subdivision (a) for
22 unprofessional conduct in that Respondent abandoned her patient in order to unlawfully use
23 controlled substances, withdrew Dilaudid, purportedly for a patient of Redlands Community
24 Hospital without documenting administration and/or wastage of drugs, obtained Fentanyl from a
25 patient for her own use, unlawfully used a controlled substance during working hours and
26 overdosed on a controlled substance, as more fully set forth in paragraphs 30-37 and incorporated
27 herein as though set forth in full.

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1 **EIGHTH CAUSE FOR DISCIPLINE**

2 **(Obtained Controlled Substances –Redlands Community Hospital)**

3 39. Respondent is subject to discipline under Code section 2762, subdivision (a) for
4 unprofessional conduct in that Respondent obtained or possessed controlled substances, to wit,
5 Dilaudid, Vicodin and Fentanyl, in violation of law, as more fully set forth in paragraphs 30-37
6 and incorporated herein as though set forth in full.

7 **SEVENTH CAUSE FOR DISCIPLINE**

8 **(Used Controlled Substances –Redlands Community Hospital)**

9 40. Respondent is subject to discipline under Code section 2762, subdivision (b) for
10 unprofessional conduct in that Respondent used controlled substances, to wit, Dilaudid, Vicodin,
11 and Fentanyl in violation of law, specifically Code section 4060 and Health and Safety Code
12 sections 11170 and 11173(a), and in a manner dangerous or injurious to herself or the public and
13 to the extent that such use impaired her ability to safely practice as a registered nurse, as more
14 fully set forth in paragraphs 30-37 and incorporated herein as though set forth in full.

15 **DISCIPLINARY CONSIDERATIONS**

16 41. To determine the degree of discipline, if any, to be imposed on Respondent,
17 Complainant alleges that on or about March 22, 2012, Respondent was terminated from the
18 Board's diversion program for reasons other than successful completion of the program.

19 **PRAYER**

20 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
21 and that following the hearing, the Board of Registered Nursing issue a decision:

22 1. Revoking or suspending Registered Nurse License Number 679031, issued to Ruth
23 Litecky Maina;

24 2. Ordering Ruth Litecky Maina to pay the Board of Registered Nursing the reasonable
25 costs of the investigation and enforcement of this case, pursuant to Business and Professions
26 Code section 125.3;

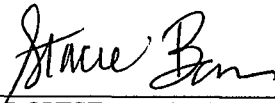
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3. Taking such other and further action as deemed necessary and proper.

DATED: OCTOBER 02, 2012


for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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